AGENDA

PUBLIC HEALTH ADVISORY BOARD
Incentives and Funding Subcommittee

February 3, 2020
12:00-1:00 pm
Portland State Office Building, 800 NE Oregon St., Conference Room 915, Portland, OR 97232

Join Zoom Meeting
https://zoom.us/j/659735928
Meeting ID: 659 735 928
(669) 900 6833

Please do not put your phone on hold – it is better to drop the call and rejoin if needed.

Subcommittee Members: Carrie Brogoitti, Bob Dannenhoffer, Alejandro Queral, Akiko Saito

Meeting Objectives
- Approve August 9, 2019 meeting minutes
- Review subcommittee scope of work and deliverables
- Discuss proposed changes to PHAB Funding Principles
- Discuss public health modernization funding formula implementation and changes for the 2021-23 biennium.

12:00-12:05 pm	**Welcome, introductions and updates** • Approve August 9, 2019 minutes	Sara Beaudrault, Oregon Health Authority
12:05-12:10 pm	**Subcommittee scope of work and deliverables** • Review scope of work, timeline and deliverables	Sara Beaudrault
12:10-12:25 pm	**PHAB Funding Principles** • Provide recommendations on proposed changes to Funding Principles that were discussed during the January PHAB meeting. • Discuss whether additional changes are needed to support the subcommittee's development of the public health modernization funding formula.	All
12:25-12:45	**Implementation of 2019 public health modernization funding formula** • Review allocation of funds to local public health authorities	All

	• Discuss feedback the subcommittee would like to receive from local public health authorities on allocation of funding. • Discuss components of the funding formula the subcommittee would like to review, and additional information needed to finalize the 2021-23 funding formula. •	
12:45-12:50 pm	**Subcommittee business** • The next meeting is scheduled for Monday, March 2 from 12:00-1:00 • If the subcommittee would like to continue to use rotating chairs to facilitate meetings, select chair for March meeting	Sara Beaudrault
12:50-12:55 pm	**Public comment**	
12:55 pm	**Adjourn**	Sara Beaudrault

Public Health Advisory Board (PHAB)
Incentives and Funding Subcommittee meeting minutes
August 9, 2019
12:00 p.m. – 1:00 p.m.

PHAB members present: Carrie Brogoitti, Akiko Saito, Dr. Bob Dannenhoffer
PHAB members absent: Dr. Jeff Luck, Alejandro Queral
Oregon Health Authority (OHA) staff: Sara Beaudrault, Cara Biddlecom, Krasimir Karamfilov

Welcome, introductions, and updates

Ms. Beaudrault introduced the meeting. She noted that, since the last subcommittee meeting, the legislative session ended with a very positive outcome for public health modernization investments. The focus of today's meeting was to show subcommittee members how the funding for the next biennium would be allocated, based on their collective recommendations.

A quorum was present. Dr. Dannenhoffer made a motion to approve the meeting minutes from the meeting on June 17, 2019. Ms. Brogoitti seconded the motion. The subcommittee approved the meeting minutes unanimously.

Modernization funding for 2019-2021

Ms. Biddlecom reminded the subcommittee that OHA received an additional $10 million from the Oregon legislature to continue to advance public health modernization in the 2019-2021 biennium. This funding brings the total up to $15 million. These resources will be used to build on the existing investment from the 2017-2019 biennium and position the public health system to fully achieve the goal of public health modernization, which is to ensure that all public health services are available to every person in Oregon.

Ms. Biddlecom remarked that OHA has been working to frame out what the local public health modernization investment would be, using the PHAB's funding principles and this subcommittee's discussion from the meeting on June 17, 2019. Other major inputs for the budgeting process have been the Public Health Modernization Manual and the 2016 Public Health Modernization Assessment.

Ms. Biddlecom noted that as OHA started to frame out the investments for this biennium, we have been in a place of being able to build on what we had started in 2017 and trying to think systematically about how the public health system can be better positioned to fully implement all of what we want to see for public health modernization in subsequent biennia. OHA has tried to fold some really important work around leadership and governance throughout the funding that OHA is going to be putting out.

Ms. Biddlecom stated that the overall budget is broken out into three categories: $10 million is going to local public health authorities; $1.2 million has been allocated to federally-recognized tribes and NARA; $3.8 millions will be retained by the OHA Public Health Division (PHD). One hundred percent of the Public Health Division investment is going to support the public health system and targeting some important state public health roles that support local and tribal public health, as well as other partners. The target areas include: health equity and cultural responsiveness, leadership and organizational competencies, assessment and epidemiology, and communicable disease control and environmental health.

Ms. Biddlecom explained that under health equity and cultural responsiveness, the PHD will use funding to retain a short-term health equity coordinator position that helped the health equity efforts at the PHD. The position will support implementation of the health equity plans at the local level going forward. Under leadership and organizational competencies, the PHD investment includes support for learning collaboratives that both LPHAs and PHD will co-participate in to figure out how to advance public health modernization and identify the structures needed to move forward in subsequent biennia. Under assessment and epidemiology, a large section of the PHD investment is going to data collection and reporting, including different ways to make data accessible and more easily used by partners at the local level. The PHD will also invest in the evaluation of the use of these funds and collect and report accountability metrics, which the PHD is legislatively required to do. Under communicable disease control and environmental health, the PHD will hire an additional position to help provide surge capacity to LPHAs on communicable disease control issues, as well as a new staff role that will be able to help identify and work with communities to look at environmental health threats and be a bridge between acute environmental health impacts on health and how we monitor and plan for those using our communicable disease control and preparedness systems.

Dr. Dannenhoffer asked what the additional staff at the PHD would be. Are people who are currently there going to be transferred to this program, or will the division hire new people? What is the plan?

Ms. Biddlecom answered that of the three positions she specifically mentioned, one has been in a limited-duration capacity since 2018. It's the health equity coordinator position. The other two positions under communicable disease control and environmental health will be new and people have not been recruited yet.

Dr. Dannenhoffer remarked that, looking at the money, those hiring expenses would not come close to $3.8 million. Are there other kinds of expenses there?

Ms. Biddlecom asked if Dr. Dannenhoffer meant under communicable disease control and environmental health.

Dr. Dannenhoffer clarified that he meant under anything. The overall story is that the $3.8 million that the subcommittee budgeted was for so many FTEs and so much programmatic stuff. Do we have that kind of budget set out?

Ms. Biddlecom answered that the PHD will share more details on positions and contracts when the information is available. The PHD is also in the process of finalizing its budget, just like LPHAs will be doing in the coming months.

Dr. Dannenhoffer stated that from a county point of view, where they have to do the budget down to the penny, and the local public health people don't get to see what the state is spending, it seems a little bit incongruous. The PHD can do itself a great favor by publishing its budget, just like LPHAs need to publish their budgets.

Ms. Biddlecom answered that the PHD would get more detail out as the budget is finalized.

Ms. Beaudrault noted that in terms of connecting the funding to the work of this subcommittee, the funding will go out according to the PHAB recommendations for use of funding. For funds to the LPHAs, we hit the $10 million threshold, which kicks on the funding formula. The subcommittee discussed funding at this level at a couple of different meetings, thinking about how to continue to support the regional partnerships, as well as get funding out to all LPHAs through the funding formula. Upon the subcommittee's request, we heard feedback provided by local public health administrators at the meeting in June. As soon as legislative session wrapped up on June 30, 2019, OHA started working with the Joint Leadership Team, which is comprised of CLHO executive leadership and PHD leadership, to take these recommendations and start operationalizing them.

Ms. Beaudrault added that the Joint Leadership Team developed a process and timeline for implementing PHAB's guidance and, ultimately, decided to allocate $3 million of the $10 million available to LPHAs for regional partnerships, with the remaining $7 million allocated to LPHAs through the funding formula. Some of the things that the Joint Leadership Team used to make that decision included looking at the budgets for the regional partnerships and trying to understand the nature of the regional work and the most successful aspects that they wanted to see funded, reviewing the evaluation to understand successes and challenges in the regional partnership model, as well as going back to the information that's been provided by local administrators about what they see as the successes and the work that needs to continue.

Ms. Beaudrault remarked that, in terms of the $3 million, funds are available and funding to existing regional partnerships will be prioritized. OHA understands that some regional partnerships might want to change configurations by either adding new counties, possibly some counties would step out of the partnership. There is possibility that we'll see some new regional partnerships interested in funding as well.

Ms. Saito stated that the $3 million is for the biennium, which comes to $1.5 million per year. That's a little bit different than what LPHAs have had. How will this determination be across the board? Will each regional partnership get the same percentage it got before? Does the subcommittee need to help in making that decision?

Ms. Beaudrault answered that the Joint Leadership Team looked at the budgets for the regional partnerships and parsed out what within these budgets is truly regional work, and what was work that went out through that model but was really work sitting within an individual county. They were able to narrow in on this $3 million by doing that. Three million is a good target to hit, in terms of continuing the truly regional aspects of the work that happened in the last biennium.

Ms. Saito asked if the Joint Leadership Team had already decided where that money is going to go for the different partnerships.

Ms. Beaudrault answered that the Joint Leadership Team had not decided. Regional partnerships will submit proposals telling OHA what they want to do and give an estimated budget later in August. That would allow OHA to see how close it is to hitting the $3 million mark. In terms of the work, the requirements are largely not changing for the regional partnerships. The funding requirements that were in place are mostly the same and will allow the regional partnerships to continue what they put into play and allow the work to evolve and progress. One thing we'll expect to see is that the partnerships implement components of the health equity plans that were developed in the previous biennium.

Ms. Beaudrault showed a slide of the distribution of the $7 million funding going out to individual LPHAs based on the funding formula. This is a big deal. The subcommittee has been working on the formula since 2016 and the formula is being used for the first time in 2019. The funding formula breaks counties into groups, based on population size. This gives an idea of the range of funding that different county population size bands will receive. We built the funding formula to keep the floor funding in place. Those floors were set by this subcommittee a couple of years ago with an expectation that not dropping lower than these floors gives each county something that they can be working from.

Ms. Beaudrault pointed out that in terms of the required work for all LPHAs, the requirements will be bucketed into three areas. Communicable disease control and health equity and cultural responsiveness are not new. This gives LPHAs that have been participating in regional partnerships, or will, an opportunity to think about how the work within their own county connects with the regional efforts. There could be some nice synergies there. Leadership and governance was the body of work Ms. Biddlecom was referring to earlier around some system-wide planning work, understanding that the legislature's expectation is to see that we are using this investment to make some sustainable system changes over the course of the biennium and strategically using funds to do the planning work for full implementation of public health modernization over time. While LPHAs will have requirements to be doing this work, the state

is also using funds to support this work. We are hoping this sets us up for some nice opportunities to think about the work that needs to happen locally, as well as what we can all be working on together statewide.

Ms. Beaudrault noted that, considering the funding formula, the extra small counties and small counties are receiving a fairly small amount of funding for the biennium compared with the extra-large counties. That was a concern of this subcommittee to think about whether the funding through the funding formula was equitable for all LPHAs. That's another question that the Joint Leadership Team has been thinking about. Their recommendation was to build the structure for the funding requirements for LPHAs around a menu concept, where instead of every LPHA having the exact same requirements and doing the exact same work, the menu concept will allow LPHAs to select objectives and strategies that are most relevant to the needs and priorities within their own county, and then to tailor their work plans to the level of work that makes sense for the level of funding that they are receiving.

Ms. Saito wondered if the menu options leadership and governance and health equity and cultural responsiveness were foundational capabilities and communicable disease control was a foundational program, where was emergency preparedness? Are we trying to mix and match, or are we trying to focus on foundational capabilities first and then programs? It seems odd to have two capabilities and one program.

Ms. Beaudrault responded that the team hadn't thought about it in that way. Leadership and governance is not the entire foundational capability around leadership and organizational competencies, although it is very similar. One thing we have learned is that even though we list out foundational capabilities like this, the reality is that the foundational capabilities are interconnected, and we are not doing health equity without doing the community partnership work and, similarly, we are not doing communicable disease planning work without bringing in emergency preparedness.

Ms. Saito noted that she would love to see that called out and have CD as part of that. If we put leadership and governance, health equity and cultural responsiveness, and emergency preparedness, that covers communicable disease control, as well as environmental health. It leaves the menu more open for people to do stuff. The emergency preparedness section at PHD doesn't get any general funds, and at the local level they are not getting general funds for emergency preparedness either, which includes CD.

Ms. Beaudrault explained that all LPHAs are required to participate in learning communities focused on governance. OHA doesn't have all the details about what it would look like to be doing local or statewide work focused on governance. We will be having those conversations with the Joint Leadership Team and local administrators over the coming weeks and months to identify the areas that we want to focus on collectively. Under the menu items for leadership and governance, each LPHA will choose from one of the buckets of work: planning for full implementation of public health modernization (i.e., thinking about the infrastructure to make

sure that the foundational capabilities are solidly in place that can be applied to any emerging threats or population health priorities), developing or enhancing partnerships to build a sustainable public system (i.e., healthcare and all sectors that are part of a public health system); implementing workforce and leadership development initiatives; developing and implementing technology improvements. LPHAs are not expected to do all of this work, but to select one area that is most relevant to a county's needs and priorities.

Ms. Beaudrault remarked that in terms of health equity and cultural responsiveness, most LPHAs that participated in a regional partnership had completed a health equity assessment and have an action plan. The work will be around implementing those action plans. The action plans that the regional partnerships developed are very robust. Some of them include very large bodies of work that will happen over an extended period of time. The requirement here will be for LPHAs to select specific areas of their health equity action plans that they want to prioritize with funding. Based on feedback from the Joint Leadership Team this week, the requirement will be to make sure there is at least one objective focusing on work that happens within the health department (e.g., staff training, workforce development around health equity, policy development), as well as work happening external to the health department (e.g., partnerships, working directly with communities, doing things differently with public health data to make sure that it is available to groups within the community that need to use it).

Dr. Dannenhoffer asked that in building these community partnerships, some of the partnerships are very specific on an equity issue or a housing issue, but some a bit broader. Is this requirement going to give counties the ability to be a bit broader? For example, there is a group in Douglas County that does housing and nursing among other things – will this be broad or narrow to communicable disease and health equity?

Ms. Beaudrault answered that this would be broader. The Joint Leadership Team wanted OHA to make sure that it gives LPHAs the exact level of flexibility that Dr. Dannenhoffer was talking about.

Dr. Dannenhoffer added that it was important to call it out because, in small communities, people are usually doing a bunch of things at once.

Ms. Beaudrault stated that for LPHAs that didn't have an assessment and action plan, that would be their focus for the first year or so of funding. Then they will move into implementing the plan for the remainder of the funding period. For communicable disease control, each LPHA will need to have an objective in their workplan around conducting jurisdiction-specific communicable disease control or prevention activities with a focus on developing infrastructure. This involves looking at the communicable disease needs and priorities and identifying a need to focus on. The overarching focus is on developing infrastructure. Selecting communicable disease needs gives an anchor for the work, but the intention is to be developing the partnerships, or doing the systems development work to prepare each LPHA to have stronger infrastructure around communicable disease control and response. Additional menu

items here are around working with partners, workforce development, and utilizing communicable diseases investigation and emergency preparedness systems to begin planning for environmental health threats.

Ms. Beaudrault noted that in terms of the funding for the tribes, OHA is working with tribal partners now to develop a concept for how funding will be used and what their priorities are for that funding. We anticipate that some funds will be used to support tribes that have not completed a tribal modernization assessment to complete an assessment, and then begin working on planning based on their assessment results. For tribes that have completed an assessment, OHA will likely be supporting them to make updates and start doing the planning work and implement. We anticipate that there may be some contractual work as well to support the federally recognized tribes and NARA in doing that work.

Ms. Saito asked if any of the tribal public health funds for doing the modernization assessment would come from the state pot.

Ms. Beaudrault answered that the funds would come from the tribal pot of $1.2 million.

Ms. Saito reiterated having the communicable disease control bucket be emergency preparedness with having still the same menu options. It would bring us up to a more system-level approach. The goal is to build the foundational capabilities first and have them solid and then the programs underneath.

Ms. Beaudrault shared that, for her, one of the biggest learnings over the last couple of years has been how to lead with the foundational capabilities. She asked the subcommittee members whether the funding approach was consistent with the direction the subcommittee provided and what level and type of information the members would like to be brought back to the subcommittee when it reconvened.

Dr. Dannenhoffer admitted that the division of the funding was slightly different than what he thought. He thought that more funding would go to the LPHAs, less to the regional partnerships, so that the LPHAs would use their own staff to do this work. He understood that the split had to made somewhere.

Ms. Saito pointed out that the Joint Leadership Team was most likely part of that discussion and they must have felt comfortable with that split, which made Ms. Saito feel comfortable because many people talked about it.

Subcommittee business

Ms. Beaudrault informed the subcommittee that the PHAB has a meeting on August 15, 2019. Ms. Biddlecom will do an overview of the legislative investment for the full board. There is no

need for a subcommittee update unless the subcommittee members would like to provide something specific from the subcommittee.

Ms. Saito remarked that the Incentives and Funding Subcommittee has been a great subcommittee. That would be her update.

Dr. Dannenhoffer seconded Ms. Saito's remark.

Ms. Beaudrault agreed that it was a pleasure to work with the subcommittee. There have been some challenging conversations this year, but she hoped the subcommittee members were happy with where things landed. The positive is that, going into the next session, all signs point to continued support for public health modernization and additional funding. The legislative session ended with a very positive outlook. That is exciting.

Ms. Beaudrault added that unless there were other needs, this subcommittee was on hiatus for the next few months. Sneak preview for PHAB later this fall, there will be an opportunity to think about the subcommittees and what they want to be working on to get into the system change work and have some exciting bodies work on their horizons. Subcommittee members are encouraged to start thinking about things that they would like to see the subcommittee engage in moving forward.

Public comment

Ms. Beaudrault invited members of the public to ask questions and provide testimony.

There was no public comment.

Closing

Ms. Beaudrault adjourned the meeting at 12:42 p.m.

PHAB Incentives and Funding subcommittee
Scope of work and timeline for 2020
January 2020, draft

Subcommittee members: Carrie Brogoitti, Bob Dannenhoffer, Alejandro Queral, Akiko Saito

Deliverables:

- **Public health modernization funding formula for 2021-23**
- Recommendations on Public Health Modernization Funding Report to Legislative Fiscal Office
- PHAB Funding Principles

Scope of work and timeline for subcommittee meetings

February	- Discuss PHAB funding principles. - Discuss implementation of 2019 public health modernization funding formula.
March	- Review feedback from LPHAs on 2019 funding allocations. - Discuss changes to base component of funding formula, based on LPHA and OHA feedback. - Hear update on OHA and CLHO Leadership work to develop system-level priorities for 2021-23.
April	- Finalize base component of funding formula. - Review methodology for incentives and matching funds components.
May	- Final review of funding formula and recommendations for regional partnership or cross-jurisdictional sharing funding.
June	- Review funding formula section of June 2020 Public Health Modernization Funding Report to Legislative Fiscal Office

Funding Principles

- Discuss proposed changes based on PHAB's January meeting.
- Discuss whether additional changes are needed to support the subcommittee's development of the 2021-23 modernization funding formula.

Public Health Advisory Board
Funding principles for state and local public health authorities
~~**February 15, 2018**~~**Updated January 2020**

The Public Health Advisory Board recognizes that funding for foundational capabilities and programs is limited, but innovations can maximize the benefit of available resources. These funding principles are designed to apply to the public health system, which means state and local public health authorities in Oregon. These funding principles can be applied to increases or decreases in public health funding.

Public health system approach to foundational programs

1. Ensure that public health services are available to every person in Oregon, whether they are provided by an individual local public health authority, through cross-jurisdictional sharing arrangements, and/or by the Oregon Health Authority.

2. Align funding with burden of disease, risk, and state and community health assessment and plan priorities, while minimizing the impact to public health infrastructure when resources are redirected.

3. Use funding to advance health equity in Oregon, which ~~may~~ includes directing funds to areas of the state experiencing a disproportionate burden of disease or where health disparities exist.

4. Use funding to incentivize changes to the public health system intended to increase efficiency and improve health outcomes, which ~~may~~ includes cross-jurisdictional sharing.

5. Align public health work and funding to ~~coordinate~~ leverage resources with health care, education and other sectors to achieve health outcomes.

Transparency across the public health system

6. Acknowledge how the public health system works to achieve outcomes, and direct funding to close the identified gaps across the system in all governmental public health authorities.

7. Improve transparency about funded work across the public health system and scale work to available funding.

Modernization funding formula implementation

- Discuss feedback the subcommittee would like to receive from LPHAs on allocation of funding.
- Discuss components of the funding formula the subcommittee would like to review, and additional information needed to finalize the 2021-23 funding formula

Public health modernization LPHA funding formula - FINAL
2019-21 biennium
August, 2019

Total biennial funds available to LPHAs through the funding formula = $7 million

		Base component									Matching and Incentive fund components		Total county allocation				
County Group	Population[1]	Floor	Burden of Disease[2]	Health Status[3]	Race/ Ethnicity[4]	Poverty 150% FPL[4]	Rurality[5]	Education[4]	Limited English Proficiency[4]		Matching Funds	Incentives	Total Award	Award Percentage	% of Total Population	Award Per Capita	Avg Award Per Capita
Wheeler	1,450	$ 30,000	$ 292	$ 543	$ 138	$ 202	$ 1,588	$ 107	$ 5		$ -	$ -	$ 32,876	0.5%	0.0%	$ 22.67	
Wallowa	7,175	$ 30,000	$ 1,751	$ 1,076	$ 411	$ 725	$ 7,858	$ 530	$ 223		$ -	$ -	$ 42,576	0.6%	0.2%	$ 5.93	
Harney	7,380	$ 30,000	$ 2,492	$ 2,394	$ 846	$ 947	$ 3,581	$ 791	$ 511		$ -	$ -	$ 41,561	0.6%	0.2%	$ 5.63	
Grant	7,400	$ 30,000	$ 1,527	$ 1,661	$ 527	$ 797	$ 8,105	$ 786	$ 282		$ -	$ -	$ 43,684	0.6%	0.2%	$ 5.90	
Lake	8,115	$ 30,000	$ 2,172	$ 1,316	$ 1,043	$ 1,228	$ 5,626	$ 1,292	$ 505		$ -	$ -	$ 43,183	0.6%	0.2%	$ 5.32	
Morrow	11,885	$ 30,000	$ 2,449	$ 3,609	$ 4,055	$ 1,370	$ 5,975	$ 3,055	$ 6,496		$ -	$ -	$ 57,010	0.8%	0.3%	$ 4.80	
Baker	16,765	$ 30,000	$ 4,308	$ 2,719	$ 1,295	$ 1,905	$ 7,528	$ 1,727	$ 754		$ -	$ -	$ 50,237	0.7%	0.4%	$ 3.00	$ 5.17
Crook	22,710	$ 45,000	$ 5,711	$ 6,592	$ 2,287	$ 2,857	$ 11,939	$ 2,860	$ 943		$ -	$ -	$ 78,189	1.1%	0.5%	$ 3.44	
Curry	22,915	$ 45,000	$ 7,925	$ 6,624	$ 2,626	$ 2,642	$ 9,713	$ 2,409	$ 1,110		$ -	$ -	$ 78,048	1.1%	0.5%	$ 3.41	
Jefferson	23,560	$ 45,000	$ 6,835	$ 5,431	$ 8,140	$ 3,201	$ 16,282	$ 3,507	$ 4,157		$ -	$ -	$ 92,552	1.3%	0.6%	$ 3.93	
Hood River	25,310	$ 45,000	$ 4,092	$ 6,112	$ 7,866	$ 2,547	$ 14,470	$ 5,374	$ 13,834		$ -	$ -	$ 99,295	1.4%	0.6%	$ 3.92	
Tillamook	26,395	$ 45,000	$ 6,762	$ 6,245	$ 3,506	$ 2,855	$ 20,121	$ 2,775	$ 2,648		$ -	$ -	$ 89,912	1.3%	0.6%	$ 3.41	
Union	26,885	$ 45,000	$ 6,215	$ 4,722	$ 2,497	$ 3,619	$ 12,397	$ 2,043	$ 1,581		$ -	$ -	$ 78,073	1.1%	0.6%	$ 2.90	
Gilliam, Sherman, Wasco	30,970	$ 105,000	$ 8,070	$ 5,930	$ 6,184	$ 3,151	$ 14,077	$ 4,250	$ 6,106		$ -	$ -	$ 152,768	2.2%	0.7%	$ 4.93	
Malheur	31,925	$ 45,000	$ 7,354	$ 11,175	$ 10,615	$ 5,113	$ 16,923	$ 6,280	$ 9,277		$ -	$ -	$ 111,737	1.6%	0.8%	$ 3.50	
Clatsop	39,200	$ 45,000	$ 10,524	$ 7,410	$ 4,764	$ 4,027	$ 16,744	$ 3,468	$ 3,661		$ -	$ -	$ 95,600	1.4%	0.9%	$ 2.44	
Lincoln	48,210	$ 45,000	$ 15,049	$ 12,112	$ 7,157	$ 6,125	$ 19,853	$ 5,319	$ 4,169		$ -	$ -	$ 114,785	1.6%	1.1%	$ 2.38	
Columbia	51,900	$ 45,000	$ 11,869	$ 12,217	$ 4,911	$ 4,809	$ 24,784	$ 5,132	$ 2,514		$ -	$ -	$ 111,235	1.6%	1.2%	$ 2.14	
Coos	63,275	$ 45,000	$ 19,268	$ 16,978	$ 7,910	$ 8,278	$ 26,612	$ 6,915	$ 3,283		$ -	$ -	$ 134,243	1.9%	1.5%	$ 2.12	
Klamath	67,960	$ 45,000	$ 19,971	$ 17,820	$ 12,567	$ 9,346	$ 27,987	$ 8,913	$ 7,523		$ -	$ -	$ 149,126	2.1%	1.6%	$ 2.19	$ 2.88
Umatilla	80,765	$ 60,000	$ 17,350	$ 21,671	$ 23,138	$ 10,058	$ 25,741	$ 15,131	$ 29,336		$ -	$ -	$ 202,425	2.9%	1.9%	$ 2.51	
Polk	82,100	$ 60,000	$ 15,355	$ 14,519	$ 15,039	$ 8,262	$ 17,894	$ 7,947	$ 14,484		$ -	$ -	$ 153,500	2.2%	2.0%	$ 1.87	
Josephine	86,395	$ 60,000	$ 26,611	$ 20,126	$ 9,450	$ 12,498	$ 42,580	$ 9,801	$ 3,885		$ -	$ -	$ 184,952	2.6%	2.1%	$ 2.14	
Benton	93,590	$ 60,000	$ 12,962	$ 16,209	$ 15,194	$ 11,498	$ 19,271	$ 4,481	$ 13,598		$ -	$ -	$ 153,211	2.2%	2.2%	$ 1.64	
Yamhill	107,415	$ 60,000	$ 20,129	$ 25,022	$ 20,888	$ 9,954	$ 26,588	$ 13,081	$ 20,065		$ -	$ -	$ 195,727	2.8%	2.6%	$ 1.82	
Douglas	111,735	$ 60,000	$ 34,639	$ 31,888	$ 11,252	$ 12,931	$ 50,419	$ 12,327	$ 4,638		$ -	$ -	$ 218,095	3.1%	2.7%	$ 1.95	
Linn	125,575	$ 60,000	$ 28,856	$ 28,946	$ 15,589	$ 14,374	$ 43,461	$ 12,809	$ 9,122		$ -	$ -	$ 213,158	3.0%	3.0%	$ 1.70	$ 1.84
Deschutes	188,980	$ 75,000	$ 33,149	$ 26,275	$ 20,180	$ 16,006	$ 57,126	$ 12,785	$ 13,728		$ -	$ -	$ 254,249	3.6%	4.5%	$ 1.35	
Jackson	219,200	$ 75,000	$ 52,080	$ 49,191	$ 34,824	$ 25,275	$ 48,255	$ 24,412	$ 25,023		$ -	$ -	$ 334,061	4.8%	5.2%	$ 1.52	
Marion	344,035	$ 75,000	$ 68,536	$ 82,241	$ 100,653	$ 40,535	$ 49,361	$ 54,070	$ 128,532		$ -	$ -	$ 598,927	8.6%	8.2%	$ 1.74	
Lane	375,120	$ 90,000	$ 80,869	$ 73,659	$ 56,665	$ 45,770	$ 71,898	$ 33,187	$ 33,739		$ -	$ -	$ 485,786	6.9%	8.9%	$ 1.30	$ 1.48
Clackamas	419,425	$ 90,000	$ 74,842	$ 75,197	$ 62,993	$ 26,028	$ 83,146	$ 29,685	$ 60,938		$ -	$ -	$ 502,829	7.2%	10.0%	$ 1.20	
Washington	606,280	$ 90,000	$ 83,945	$ 98,345	$ 173,166	$ 44,487	$ 37,185	$ 54,900	$ 190,854		$ -	$ -	$ 772,881	11.0%	14.5%	$ 1.27	
Multnomah	813,300	$ 90,000	$ 162,706	$ 160,691	$ 208,288	$ 84,912	$ 11,580	$ 76,185	$ 239,142		$ -	$ -	$ 1,033,506	14.8%	19.4%	$ 1.27	$ 1.26
Total	**4,195,300**	**$ 1,860,000**	**$ 856,667**	**$ 856,667**	**$ 856,667**	**$ 428,333**	**$ 856,667**	**$ 428,333**	**$ 856,667**		$ -	$ -	**$ 7,000,000**	**100.0%**	**100.0%**	**$ 1.67**	**$ 1.67**

[1] Source: Portland State University Certified Population estimate July 1, 2018
[2] Source: Premature death: Leading causes of years of potential life lost before age 75. Oregon death certificate data, 2012-2016.
[3] Source: Quality of life: Good or excellent health, 2012-2015.
[4] Source: American Community Survey population 5-year estimate, 2013-2017.
[5] Source: U.S. Census Bureau, Population estimates,2010

County Size Bands

Extra Small	Small	Medium	Large	Extra Large
up to 20,000	20,000-75,000	75,000-150,000	150,000-375,(	above 375,000

Program Element 51: Public Health Modernization award amounts to LPHAs
Funding period: October 1, 2019 through June 30, 2021
December, 2019

		Subsection 1: LPHA Leadership, Governance and Program Implementation			Subsection 2: Regional Partnership Implementation (Funding to Fiscal Agent)			
County Group	Population[1]	Original Award	Modifications	Final Subsection 1 Award Amount	Subsection 2: Regional Partnership Award 10/1/19-6/30/21[2]	Subsection 2: requested award modifications	Final Subsection 2 Award Amount	Total/Final Award (Subsection 1 + Subsection 2)
Wheeler[4]	$ 1,450	$ 32,876	$ (2,000)	$ 30,876				**$ 30,876**
Wallowa[3]	$ 7,175	$ -		$ -				**$ -**
Harney[4]	$ 7,380	$ 41,561	$ (2,000)	$ 39,561				**$ 39,561**
Grant[4]	$ 7,400	$ 43,684	$ (2,000)	$ 41,684				**$ 41,684**
Lake[4]	$ 8,115	$ 43,183	$ (2,000)	$ 41,183				**$ 41,183**
Morrow[4]	$ 11,885	$ 57,010	$ (2,000)	$ 55,010				**$ 55,010**
Baker[4]	$ 16,765	$ 50,237	$ (2,000)	$ 48,237				**$ 48,237**
Crook	$ 22,710	$ 78,189		$ 78,189				**$ 78,189**
Curry	$ 22,915	$ 78,048		$ 78,048				**$ 78,048**
Jefferson[5]	$ 23,560	$ 92,552	$ (46,276)	$ 46,276				**$ 46,276**
Hood River[4]	$ 25,310	$ 99,295	$ (2,000)	$ 97,295				**$ 97,295**
Tillamook	$ 26,395	$ 89,912		$ 89,912				**$ 89,912**
Union[4]	$ 26,885	$ 78,073	$ (2,000)	$ 76,073				**$ 76,073**
Gilliam, Sherman, Wasco[4]	$ 30,970	$ 152,768	$ (6,000)	$ 146,768	$ 466,637	$ 24,000	$ 490,637	**$ 637,405**
Malheur[4]	$ 31,925	$ 111,737	$ (2,000)	$ 109,737				**$ 109,737**
Clatsop	$ 39,200	$ 95,600		$ 95,600	$ 376,637		$ 376,637	**$ 472,237**
Lincoln	$ 48,210	$ 114,785		$ 114,785				**$ 114,785**
Columbia	$ 51,900	$ 111,235		$ 111,235				**$ 111,235**
Coos	$ 63,275	$ 134,243		$ 134,243				**$ 134,243**
Klamath	$ 67,960	$ 149,126		$ 149,126				**$ 149,126**
Umatilla	$ 80,765	$ 202,425		$ 202,425				**$ 202,425**
Polk	$ 82,100	$ 153,500		$ 153,500				**$ 153,500**
Josephine	$ 86,395	$ 184,952		$ 184,952				**$ 184,952**
Benton	$ 93,590	$ 153,211		$ 153,211				**$ 153,211**
Yamhill	$ 107,415	$ 195,727		$ 195,727				**$ 195,727**
Douglas	$ 111,735	$ 218,095		$ 218,095	$ 399,137		$ 399,137	**$ 617,232**
Linn	$ 125,575	$ 213,158		$ 213,158				**$ 213,158**
Deschutes[5]	$ 188,980	$ 254,249	$ 46,276	$ 300,525	$ 466,637		$ 466,637	**$ 767,162**
Jackson	$ 219,200	$ 334,061		$ 334,061				**$ 334,061**
Marion	$ 344,035	$ 598,927		$ 598,927	$ 354,137		$ 354,137	**$ 953,064**
Lane	$ 375,120	$ 485,786		$ 485,786	$ 444,137		$ 444,137	**$ 929,923**
Clackamas	$ 419,425	$ 502,829		$ 502,829				**$ 502,829**
Washington	$ 606,280	$ 772,881		$ 772,881				**$ 772,881**
Multnomah	$ 813,300	$ 1,033,506		$ 1,033,506	$ 435,137		$ 435,137	**$ 1,468,643**
Total	**$ 4,195,300**	**$ 6,957,424**		**$ 6,933,424**	**$ 2,942,459**	**$ 24,000**	**$ 2,966,459**	**$ 9,899,883**

[1] Source: Portland State University Certified Population estimate July 1, 2018
[2] A portion of the $3 million in funding to Regional Partnerships was allocated for the 7/1/19-9/30/19 quarter. Unspent funds from this quarter were distributed to Regional Partnerships
[3] The Wallowa County allocation of 42,576 is used by OHA-PHD to provide communicable disease services.
[4] Most counties that participate in the EOMC regional partnership transferred a portion of its Sub-1 funds to NCPHD Sub-2. The amount of funds transferred ranged from $2,000 to $6,000
[5] Jefferson County transferred a portion ($46,276) of its Sub-1 funds to Deschutes County Sub-1

County Size Groups
Extra Small
Small
Medium
Large
Extra Large

LPHA funding formula survey
January 2020, draft

Background

In 2019 Oregon Health Authority allocated approximately $10.3 million to local public health authorities for public health modernization. Funds were allocated as follows:

- $7 million to LPHAs through the public health modernization funding formula.
- $3.3 million to regional partnerships, covering 32 of 36 counties.

The Public Health Advisory Board will develop the 2021-23 public health modernization funding formula between February and May. To inform its work, the PHAB Incentives and Funding subcommittee is soliciting feedback from local public health authorities on:

- 2019-21 distribution of funding to every LPHA through the public health modernization funding formula; and
- 2019-21 allocation of funds to regional partnerships.

Please respond to the following questions by XXXX.

Survey questions

Q1. What is your county name?

- Dropdown options

Q2: What is your county size band on the public health modernization funding formula?

- Extra small
- Small
- Medium
- Large
- Extra large

Q3: Does your county currently participate in a modernization regional partnership?

- Yes
- No

Funding to LPHAs through the public health modernization funding formula

The 2019-21 funding formula distributed funding as follows:

- *Approximately $1.8M to "floor" funding. Floor funding amounts ranged from $30,000 for extra small counties to $90,000 for extra large counties. The floor amount in the funding formula is intended to ensure every LPHA has enough funds to conduct a basic level of work to meet Program Element requirements. In most cases, floor funding favors extra small and small counties.*
- *Approximately $5.2M to indicators. LPHA allocations are calculated based on each county's rank on a set of demographic and health status indicators, and the county's population. In most cases, indicators favor large and extra large counties.*

Q3: Given the total funding available for 2019-21, the funding formula:

- Use sliding scale ranging from
    - "Favored extra small/small counties"
    - "Fairly distributed funds across county size bands" (mid-point on sliding scale)
    - "Favored extra large/large counties"
- Other/comments

Q4: The amount of funding my LPHA received was enough to conduct the work included in Program Element 51.

- Likert scale from "strongly disagree" to "strongly agree"
- Other/comments

Q5: For future funding formulas, I would like PHAB to consider:

- Allocating a bigger proportion of funds to floor funding
- Allocating a bigger proportion of funds to health status and demographic indicators
- Other/comments

Q6: If the same level of funding is available in 2021-23, I recommend that PHAB:

- Retain the current split of funding across individual LPHAs and regional partnerships.
- Direct more funding to individual LPHAs.
- Direct more funding to regional partnerships or other cross jurisdictional sharing models.
- Other/comments

Funding to regional partnerships

Q7: How could PHAB improve funding for regional partnerships, cross-jurisdictional sharing, or other shared service delivery models?

- PHAB should not direct a portion of modernization funding toward regional partnerships
- PHAB should increase funding for regional partnerships
- PHAB should decrease funding for regional partnerships
- PHAB should build incentives for regional partnerships into the funding formula
- Other/comments

Subcommittee business

- The next subcommittee meeting is scheduled for March 2 from 12:00-1:00
- Decide whether to use rotating chairs to facilitate meetings. If yes, select chair for March meeting.

Public Comment

Adjourn